Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: INJURED WORKERS PHARMACY, LLC P.O. BOX 338 METHUEN MA 01844	MFDR Tracking #: M4-09-7464-01 DWC Claim #: Injured Employee: Date of Injury:
Respondent Name and Representative Box: TEXAS MUTUAL INSURANCE CO Rep Box 54	Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Enclosed please find invoices that had previously been submitted for payment. The attached invoices have not been paid in full. The Texas State Workers' Compensation Board has established a fee schedule for prescription medications. The fee schedule states a reimbursement rate of AWP*1.09 + $4.00 for brand medication and AWP*1.25 + $4.00 for generic. As we have no contract in place with your company, we ask that you please reconsider the attached invoices for payment in full, as these invoices were billed correctly at Texas rates."

Principal Documentation:

1. DWC 60 package
2. Amount in Dispute - $381.28
3. Pharmacy Bills
4. Explanation of Benefits

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "… As the requestors in this dispute, Injured Workers Pharmacy has the burden of proof. Because Injured Workers Pharmacy failed to supply Texas Mutual with any information that would establish the U&C charge for this medication, Texas Mutual priced the medications using the best information available… Injured Workers Pharmacy, located in Massachusetts, alleges that it is entitled to bill and received the fee guideline's formula (AWP+) as set forth in 29 Tex. Admin. Code §134.503. It then appears to complain that Texas Mutual refused to pay the amount billed. In fact, Texas Mutual did not pay the amount billed because the amount bill was **not** the MAR in this case. It appears from Injured Workers Pharmacy's correspondence, including its attached request for reconsideration, that it believes it is entitled to the AWP+ regardless of whether the usual and customary amount for the medication is less than the AWP+ price. This is incorrect… This case is controlled by the Pharmacy Fee Guideline… The fee guideline provides that the MAR is the lesser of (1) the pharmacy's U&C charge for same or similar service; (2) a fee established by a formula based on an "average wholesale price"; or (3) a contract amount… As Injured Workers Pharmacy claims, Texas Mutual has not contract[ed] with Injured Workers Pharmacy, and the amount charged by Injured Workers Pharmacy is the formula (AWP+) price. Thus, the issue here is whether Injured Workers Pharmacy charges for the services in dispute to Texas Mutual are more than or equal to the U&C charge for the same or similar service… Medical Fee Dispute Resolution ("MFDR") has decided at least three cases in which it required a pharmacy to establish that its workers' compensation charges were the same or similar to those incurred by patients outside the workers' compensation system… The controlling legal standards have not changed since these decisions were issued in December 2002. Thus, Injured Workers Pharmacy's request for additional compensation should be denied because it has not demonstrated that the U&C price is higher than the amount already paid by Texas Mutual… Alternatively, to resolve this dispute, MFDR should require Injured Workers Pharmacy to present data showing the amounts Injured Workers Pharmacy is paid by other customers for similar formulation of the medications at issue during the same timeframe as these services were rendered. With such data in hand, the pharmacy's actual U&C charges for these drugs could be determined. "

Principal Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	Pharmaceuticals in Dispute	Denial Codes	Amount in Dispute	Amount Ordered
06/11/08, 11/13/08	LYRICA 75 MG CAPSULE – 75MG (28-day supply)	CAC-217, 517, CAC-W4, 891	$81.28	$0.00
06/11/08	CYMBALTA 20 MG CAPSULE – 20 MG (28-day supply)	CAC-217, 517, CAC-W4, 891	$22.71	$0.00
06/11/08, 11/13/08	AMBIEN CR 12.5 MG TABLET – 12.5MG (28-day supply)	CAC-217, 517, CAC-W4, 891	$55.26	$0.00
11/13/08	MELOXICAM 15 MG TABLET – 15MG (28-day supply)	CAC-217, 517, CAC-W4, 891	$68.32	$0.00
11/13/08	LIDODERM 5% PATCH – 5MG (30-day supply)	CAC-217, 517, CAC-W4, 891	$42.28	$0.00
11/13/08	KADIAN 30 MG CAPSULE SR – 30MG (30-day supply)	CAC-217, 517, CAC-W4, 891	$24.80	$0.00
11/13/08	HYDROCODONE-APAP 10-325 TABLET – 10-325 (30-day supply)	CAC-217, 517, CAC-W4, 891	$40.97	$0.00
11/13/08	AMITIZA 24 MCG CAPSULES – 24MCG (30-day supply)	CAC-91, 791, CAC-217, 517, CAC-W4, 891	$45.66	$0.00
Total /Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Requestor is a "health care provider" as defined by the Texas Workers' Compensation Act. *See Tex. Lab. Code Ann.* §401.011 (22) (defining "health care provider" as a health care facility or health care practitioner) *and* §401.011(19)(E) (defining "health care" to include a prescription drug, medicine, or other remedy). Requestor dispensed LYRICA 75 MG CAPSULE – 75MG (28-day supply) to the claimant on 06/11/08 and 11/13/08; CYMBALTA 20 MG CAPSULE – 20 MG (28-day supply) to the claimant on 06/11/08; AMBIEN CR 12.5 MG TABLET – 12.5MG (28-day supply) to the claimant on 06/11/08 and 11/13/08; MELOXICAM 15 MG TABLET – 15MG (28-day supply) to the claimant on 11/13/08; LIDODERM 5% PATCH – 5MG (30-day supply) to the claimant on 11/13/08; KADIAN 30 MG CAPSULE SR – 30MG (30-day supply) to the claimant on 11/13/08; HYDROCODONE-APAP 10-325 TABLET – 10-325 (30-day supply) to the claimant on 11/13/08; and AMITIZA 24 MCG CAPSULES – 24MCG (30-day supply) to the claimant on 11/13/08. Requestor billed respondent $1,847.99 for this service.

2. In accordance with Tex. Admin. Code Sections §§133.305, 133.307 and 133.308 the prescribed medication, MELOXICAM 15 MG TABLET – 15MG for date of service 06/11/08 was denied for medical necessity. Medical Fee Dispute Resolution does not have the authority to adjudicate medical necessity issues; therefore this medication, on this date of service will not be considered in this review.

3. Respondent reimbursed the Requestor $1,466.71 for these services. The reduced payment was based on payment exception codes:

   - "CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration"
   - "CAC-91 – Dispensing Fee Adjustment."
   - "CAC-217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement."
   - "517 – Paid at est. U&C based on research, Labor Code Sec 413.043, and 2002 PFG, 29 Tex: Admin Code 134.502 to electronic bill…"
   - "791 – This item is reimbursed as a brand-name prescribed drug."
   - ""891 – The insurance company is reducing or denying payment after reconsideration".

4. Requestor filed a request for medical fee dispute resolution seeking $381.28 in additional reimbursement from the Respondent.

Findings

1. Tex. Lab. Code Ann. §413.031(c) provides that "in resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules."

2. 28 Tex. Admin. Code § 134.503 governs reimbursement for pharmaceuticals. Pursuant to 28 Tex. Admin. Code §134.503(a), the maximum allowable reimbursement (hereinafter MAR) for LYRICA 75 MG CAPSULE – 75MG (28-day supply); CYMBALTA 20 MG CAPSULE – 20 MG (28-day supply); AMBIEN CR 12.5 MG TABLET – 12.5MG (28-day supply; MELOXICAM 15 MG TABLET – 15MG (28-day supply); LIDODERM 5% PATCH – 5MG (30-day supply); KADIAN 30 MG CAPSULE SR – 30MG (30-day supply); HYDROCODONE-APAP 10-325 TABLET – 10-325 (30-day supply); and AMITIZA 24 MCG CAPSULES – 24MCG (30-day supply) and shall be the **lesser of**:
   (1) The provider's usual and customary charge for the same or similar service;
   (2) The fees established by a formula based on the average wholesale price (AWP) determined by utilizing a nationally recognized pharmaceutical reimbursement system (e.g. Redbook, First Data Bank Services) in effect on the day the prescription drug is dispensed; and
   (3) A negotiated contract amount.

3. 28 Tex. Admin. Code §134.503 (a) (3) does not apply in this case because the information provided by the parties supports that no contract existed between the Requestor and Respondent for the services in dispute.

4. In this case, the MAR for LYRICA 75 MG CAPSULE – 75MG (28-day supply); CYMBALTA 20 MG CAPSULE – 20 MG (28-day supply); AMBIEN CR 12.5 MG TABLET – 12.5MG (28-day supply; MELOXICAM 15 MG TABLET – 15MG (28-day supply); LIDODERM 5% PATCH – 5MG (30-day supply); KADIAN 30 MG CAPSULE SR – 30MG (30-day supply); HYDROCODONE-APAP 10-325 TABLET – 10-325 (30-day supply); and AMITIZA 24 MCG CAPSULES – 24MCG (30-day supply) is the **lesser of** 28 Tex. Admin. Code §134.503(a)(1) ("U & C amount") and §134.503(a)(2) ("Formula amount").

5. In order to determine the MAR under 28 Tex. Admin. Code 134.503(a), the Requestor must establish its usual and customary charge for the same or similar service. On September 22, 2009, the Division asked the Requestor to provide the Division with information or documentation to sufficiently support Requestor's usual and customary charge for the items in dispute. The requestor provided information showing amounts the Requestor billed other carriers for various other pharmaceuticals. This information shows that, except in one case, the carrier reimbursed the Requestor for the amount billed by the Requestor. The requestor argues that this information shows that the Requestor has billed other carriers at the Texas mandated fee schedule and has been reimbursed at that rate. The Division concludes that this information does not sufficiently support that the amount billed is the Requestor's usual and customary charge for LYRICA 75 MG CAPSULE – 75MG (28-day supply); CYMBALTA 20 MG CAPSULE – 20 MG (28-day supply); AMBIEN CR 12.5 MG TABLET – 12.5MG (28-day supply; MELOXICAM 15 MG TABLET – 15MG (28-day supply); LIDODERM 5% PATCH – 5MG (30-day supply); KADIAN 30 MG CAPSULE SR – 30MG (30-day supply); HYDROCODONE-APAP 10-325 TABLET – 10-325 (30-day supply); and AMITIZA 24 MCG CAPSULES – 24MCG (30-day supply).

6. Because the Division has not been provided with sufficient documentation to determine the usual and customary charge for LYRICA 75 MG CAPSULE – 75MG (28-day supply); CYMBALTA 20 MG CAPSULE – 20 MG (28-day supply); AMBIEN CR 12.5 MG TABLET – 12.5MG (28-day supply; MELOXICAM 15 MG TABLET – 15MG (28-day supply); LIDODERM 5% PATCH – 5MG (30-day supply); KADIAN 30 MG CAPSULE SR – 30MG (30-day supply); HYDROCODONE-APAP 10-325 TABLET – 10-325 (30-day supply); and AMITIZA 24 MCG CAPSULES – 24MCG (30-day supply), the MAR, or the lesser of the U&C amount charge and the formula amount, cannot be determined.

Conclusion

The Division concludes that Requestor has failed to establish that it is due additional reimbursement in the amount of $381.28. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Tex. Lab. Code Ann. §401.011	28 Tex. Admin. Code §133.305	28 Tex. Admin. Code §133.308
Tex. Lab. Code Ann. §413.031	28 Tex. Admin. Code §133.307	28 Tex. Admin. Code §134.503

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	10/20/10 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in 28 TAC § 148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.